MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-B

CERTIFICATE OF DEATH

06359

Reg. Diat. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 75 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME James Albert Angell

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary A. Angell
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1854

8. AGE: Years	Months	Days	If less than one day
85	10	22	hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Retired School teacher
11. Industry or business
FATHER 12. Name William Angell
13. Birthplace Md.
MOTHER 14. Maiden name Ellen Slagenhaupt
15. Birthplace Md.
16. Informant Mrs. Mary A. Angell
Address Taneytown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1940 (month) (day) (year)
Cemetery or crematory Mt. Pleasant
Location Taneytown, Md.
18. Funeral director C. O. FUSS & SON
Address Taneytown, Md.
19. July 2, 1940 (Date rec'd by registrar) Ethele M Mehring Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1940, at 2:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1st 1937 to June 30th 1940, and that I last saw h me alive on June 24th 1940.

	DURATION
Immediate cause of death Uremia	1 mo
Due to Carcinoma of Prostate	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. M. Benner MD
M. D. or other
Address Taneytown Md Date signed July 2nd 1940

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

C6360

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto. City
City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3700 Chatham Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Farley Blair

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hattie Blair
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1863

8. AGE: Years	Months	Days	If less than one day
76	11	18	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business:
FATHER 12. Name: Lowellyn Blair
13. Birthplace: Pa.
MOTHER 14. Maiden name: Christine Delahey
15. Birthplace: Baltimore, Md.
16. Informant: Records Springfield State Hosp.
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1 1940 (month) (day) (year)
Cemetery or crematory: London Park Cemetery
Location: Baltimore Md
18. Funeral director: Wm. J. Tubner & Son
Address: North & Pa. Ave. Baltimore Md
19. 6-30-1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30, 1940 at 12:48 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 1940, to June 30 1940 and that I last saw him alive on June 29, 1940

Immediate cause of death	DURATION
Coronary Sclerosis	More than 5 years
Due to: Cardiac Infarc	1 Mo.
Due to:	
Other conditions: Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Virginia Berger M.D.
M. D. or other
Address: Springfield State Hosp. Date signed: 6/30/40

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-0)

CERTIFICATE OF DEATH

66361

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Carroll

City or town Taneytown, Md (P. D.)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown Md. R. D. 1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Filmore Samuel Bowers.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

B (b) Name of husband or wife Susan (Myers) Bowers

6(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Jan - 16 - 1856

8. AGE:

Years	Months	Days	If less than one day
84	5	11	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Retired Farmer (Retired 1934)

11. Industry or business Farm

FATHER 12. Name David Bowers

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Elisa Stultz

MOTHER 15. Birthplace Maryland.

16. Informant Maurice D Bowers

Address Littlestown Pa

17. Burial Piney Creek Brethern Cem. Date thereof June-30-1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Piney Creek Brethern Cem. Near Taneytown Md

18. Funeral director J. M. Little & Son

Address Littlestown Pa. Reg. R. A. L.

19. June 27 1940 (Date rec'd by registrar) Mary B. Witt Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27th 1940, at 7.15 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 13 1939 to June 24 1940 and that I last saw him alive on June 24 1940.

	DURATION
Immediate cause of death Chronic Interstitial Nephritis	?
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice D. Bowers M. D. or other

Address Taneytown Md Date signed 6-27-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 3 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

06362

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 mos., 17 days

Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2407 Puget St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: LILLY BELLE BLOCKER

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22, 1922

8. AGE:

Years	Months	Days	If less than one day
18	0	6	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Unknown

FATHER
12. Name: Ira Blocker
13. Birthplace: Richland County, S. C.

MOTHER
14. Maiden name: Sarah Watkins
15. Birthplace: Brooklyn, Maryland

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1. 1940 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Balto Md.

18. Funeral director: Mrs S. T. Hemsley

Address: 578 W Biddle St.

19. 6/28/40 19 (Date rec'd by registrar) Albert R. Swankham Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1940 19 6:40 A.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11 1940, to June 28 1940, and that I last saw her alive on June 28 1940.

Immediate cause of death: Tbc. meningitis
Pulmonary Tuberculosis

Due to: --

Due to: --

Other conditions: --
(Include pregnancy within 3 months of death)

Major findings:
Dt operations: --
Dt autopsy: --

DURATION: 14 days
Feb. 1940

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 6/28/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06363

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Willis Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Willis Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Maria A. Brooks

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6 (b) Name of husband or wife: Joseph D. Brooks

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1861

8. AGE: Years	Months	Days	If less than one day
78	11	6	hrs. min.

9. Birthplace: Mount Airy, Carroll, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Wesley P. Gosnell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Frances L. Demmitt
15. Birthplace: Maryland

16. Informant: Wesley C. Brooks
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15, 1940 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/14 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 1940, at 4 p. m.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 30th 1940, to June 13th 1940.
and that I last saw her alive on June 13th 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 14 days

Due to: arteriosclerosis — DURATION: Syn.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: T. Billingsley M. D. or other

Address: Westminster, Md. Date signed 6/14/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

06364

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Emory rco — Md (Rural) -
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) 10 days 5-27-40 — 6-6-40

Stay in this community (yrs., or mos., or days) 83 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Emory - Md - (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME ANNA Carr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White	Widowed.

6 (b) Name of husband or wife Thomas R. Carr.

6(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1857

8. AGE: Years	Months	Days	If less than one day
83	4	13.	——hrs. ——min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Rufus Ickehart.

13. Birthplace Maryland.

MOTHER 14. Maiden name Elizabeth Phelps.

15. Birthplace Maryland.

16. Informant Thomas. B. Carr.

Address Upperco, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27/40 (month) (day) (year)

Cemetery or crematory Emory, Carroll Co

Location Emory, Carroll Co

18. Funeral director Edward Tipton

Address Hampstead Md

19. June 25 1940 (Date rec'd by registrar) Mildred S. Hughes (Deputy) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1940, at 2 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1940, to June 25 1940, and that I last saw her alive on June 22 1940.

	DURATION
Immediate cause of death Terminal - Broncho Pneumonia	4 Days.
Due to Sub-Caput fracture Left Femur	28 Days.
Due to Arterio-Sclerotic Cardio-Vascular Disease.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of May 27 1940

Where did injury occur? Baltimore (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Slipped descending Stairs Injured at work?

23. SIGNATURE Joseph E. Bauk M.D.
M. D. or other

Address Hampstead Md Date signed June 25 1940

RECEIVED
JUL 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

06365

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:

County Carroll

City or town Rural Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: (Winfield)

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Carroll

City or town Rural Sykesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. (Winfield)
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Walter Condon

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lulu Mamie Condon

6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) September 2 1870

8. AGE: Years 69 Months 9 Days 19 If less than one day ___ hrs. ___ min.

9. Birthplace New Windsor Carroll, Md
(Town, county, and state)

10. Usual occupation Raw Sawmill. Now retired

11. Industry or business

FATHER
12. Name Lloyd Condon
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Jane Barnes
15. Birthplace Maryland

16. Informant Mrs. Mamie Condon

Address Sykesville, Md. R.R.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof June 23, 1940
(month) (day) (year)

Cemetery or crematory Ebenezer

Location Winfield Carroll Co. Md.

18. Funeral director C. M. Waltz

Address Winfield Md.

19. June 23 1940 Edna M. Hewitt
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1940, at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___,

and that I last saw h___ alive on ___ 19___.

Immediate cause of death ~~Hemi~~ Cerebral Hemorrhage

Due to Arterio-Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION

5 yrs.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jas. T. Marsh, Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 6/21/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 6 1940
BUREAU V. S.

06366

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Winfield Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Winfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Westminster, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: None.

3. (a) FULL NAME: Columbus A. Costley.

3. (b) Social Security Number: No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married.

6.(b) Name of ~~husband~~ or wife: Eleanor Costley

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1868

8. AGE:

Years	Months	Days	If less than one day
71	10	13	hrs. min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER
12. Name: John Costley
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Mary Jane Wilkins
15. Birthplace: Maryland

16. Informant: Mrs. Eleanor Costley

Address: R.D. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 20, 1940 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Covers Corner Carroll Co. Md

18. Funeral director: C.M. Waltz

Address: Winfield. Md.

19. 6 – 19 – 1940 (Date rec'd by registrar) E.M. Farver Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1940, at 1:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937 19 , to death 19

and that I last saw him alive on 6-14-40 19

Immediate cause of death: chronic myocarditis arteriosclerosis

Due to: Senility

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W.H. Lawson. M.D. M. D. ~~or other~~

Address: Sykesville Date signed 6/17/40.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06367

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs
Hospital, institution, or street address where death occurred: Springfield State Hosp.
How long in hospital or institution? 9 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #7
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Deardorff

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1914

8. AGE: Years	Months	Days	If less than one day
25	8	30	hrs. min.

9. Birthplace: Carroll Co.
(Town, county, and state)
10. Usual occupation: Odd jobs
11. Industry or business:
FATHER 12. Name: Clayton Deardorff
13. Birthplace: Pa.
MOTHER 14. Maiden name: Sarah Kuntz
15. Birthplace: Carroll Co.
16. Informant: Records S.S.H.
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12, 1940 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster Maryland
18. Funeral director: H Bankard & Son
Address: Westminster, Maryland
19. June 9 1940 (Date rec'd by registrar) C Harry Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 1940, at 8:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 1939, to June 8 1940 and that I last saw him alive on June 8 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Reported 5/2 2/36
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alan Jackson M.D. M. D. or other
Address: Springfield State Hosp. Date signed: 6/8/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (113) Reg. Dist. No. 78

06368

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Rural Mt. Airy Md. (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 2 (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Daniel W. Wudderar

3 (b) If veteran, name war

3 (c) Social Security No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1863

8. AGE: Years 76 | Months 9 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co. Md. (Town, county and state)

10. Usual occupation Machinist

11. Industry or business Harvester Co.

FATHER 12. Name Henry W. Wudderar
13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Annie R. Callaberry
15. Birthplace Frederick Co. Md.

16 (a) Informant Estella G. Hoffman
(b) Address Mt. Airy Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24-40 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Cem.
Location Winfield Md.

18 (a) Funeral director H. D. Hartzler & Sons
(b) Address New Windsor, Md.

19 (a) June 22 1940 (Date rec'd by registrar) (b) E. M. Fraver Local Registrar

MEDICAL CERTIFICATION

20. Date of death June 22 1940, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20th 1940, to June 22nd 1940, and that I last saw him alive on June 22nd 1940.

Immediate cause of death	Duration
Acute Gastritis	2 days
Due to Low blood pressure + general debility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. G. Otterby (M. D. or other)
Address New Windsor Md. Date signed 6/22/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

06369

CERTIFICATE OF DEATH

Reg. Dist. No. 72

1. PLACE OF DEATH:

County Carroll

City or town Silver Run
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Westminster R. D. 1

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 84-3-10

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster R. D. 1 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jerome Dutterer

3. (b) Social Security Number ✓

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. (Hull) Dutterer

6(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) March-8-1856

8. AGE: Years 84 | Months 3 | Days 10 | If less than one day ___ hrs. ___ min.

9. Birthplace Carroll Co. Maryland.
(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Farm.

FATHER
12. Name James Dutterer
13. Birthplace Carroll Co. Maryland

MOTHER
14. Maiden name Lydia Ann Humbert
15. Birthplace Carroll Co. Maryland.

16. Informant J. Irwin Dutterer
Address Westminster Md. R.#2

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof June-21-1940
(month) (day) (year)

Cemetery or crematory Cemetery

Location Silver Run, Md.

18. Funeral director J. W. Little & Son
Address Littlestown, PA. Per R.A.L.

19. June 20th 1940. Calvin E. Bankert
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1940, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 16 1939, to June 18 1940, and that I last saw him alive on June 18 1940.

Immediate cause of death Chronic myocarditis and myocardial degeneration — DURATION 10 yrs

Due to

Due to

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. S. Potter M.D.
M. D. or other

Address Littlestown, Pa Date signed June 19, 19

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06370

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Melrose

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 86

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Melrose Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(e) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Eisenhuth

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

B (b) Name of husband or wife: Andrew Eisenhuth (Deceased)

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1853

8. AGE: Years 86 | Months 6 | Days 26 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business

FATHER 12. Name: Frances Bowman

13. Birthplace: Germany

MOTHER 14. Maiden name: Johanna Stwartz

15. Birthplace: Germany

16. Informant: William Eisenhuth

Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-40 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Manchester Md

18. Funeral director: Jacob Wirth's Sons

Address: Manchester Md

19. June 11 1940 (Date rec'd by registrar) Mrs. M. P. L. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1940, at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1940, to June 9 1940, and that I last saw h[illegible] alive on June 2 1940

Immediate cause of death: Arteriosclerosis — DURATION 1

Due to

Due to

Other conditions: Chr. Myocarditis — 1

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE William R S Denner M. D. or other

Address Manchester Md Date signed 6/10/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06371

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 5 mos., 30 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Hyattsville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: St. Mary's Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: MARSHALL EWELL

3. (b) Social Security Number: ~~none~~ 579-12-9932

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Arita Ewell

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): April 4, 1908

8. AGE: Years	Months	Days	If less than one day
32	2	23	____ hrs. ____ min.

9. Birthplace: Foxear, Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER

12. Name: Wesley Ewell

13. Birthplace: Foxear, Virginia

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof June 30 /40 (month) (day) (year)

Cemetery or crematory: Hyattsville md

Location: "

18. Funeral director: F Gaudio Sons

Address: Hyattsville md

19. 6/27/40 (Date rec'd by registrar) 19____ Albert R. Swanson Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27, 1940 at 11:00 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28 1939 to June 27 1940, and that I last saw h- im- alive on June 27, 1940.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings: --

Of operations: --

Of autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) -- (County) -- (State)

Injured at home, farm, industry, public place (where?)

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 6/27/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

06372

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr. 4 mo. 13 da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 6 yr. 4 mo. 13 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 818 General Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Agnes Gilboe

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23, 1872

8. AGE:

Years	Months	Days	If less than one day
67	11	13	hrs. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Michael Gilboe

13. Birthplace: Ireland.

MOTHER 14. Maiden name: Mary Redihan

15. Birthplace: Ireland.

16. Informant: Hospital Records

Address: Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 6, 1940 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: 4300 Old Frederick Rd.

18. Funeral director: Elmer O. Conklin

Address: 924 E. Eager St. Baltimore

19. June 6 1940 (Date rec'd by registrar) A. Harry Weber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1940, at 9.40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 2 1934, to June 5 1940

and that I last saw h.. alive on June 5 1940

Immediate cause of death	DURATION
Arteriosclerosis	1934
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Maud M Rees M.D.

M. D. or other

Address: Sykesville Md Date signed: 6-5-40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06373

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 7 mos., 15 days

Stay in this community (yrs., or mos., or days) above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 7 N. Eden St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MARY NEEL GREEN

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1934

8. AGE:

Years	Months	Days	If less than one day
6	3	26	hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Scholar

11. Industry or business School

FATHER

12. Name Frank Green

13. Birthplace ?

MOTHER

14. Maiden name Mary Taylor

15. Birthplace Alexander, N. C.

16. Informant Dr. Reuben Hoffman

Address Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 11-40 (month) (day) (year)

Cemetery or crematory City Mt Olivet

Location Balto. Md.

18. Funeral director Mrs. S. T. Hemsley ROBERT WILLIAMS

Address 528 N. Biddle St. 165 McElderry

19. 6/9/40 (Date rec'd by registrar) 19 Albert R. Swanborn Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9, 1940 19 , at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25, 1939 19 to June 9, 1940 19 , and that I last saw h er alive on June 9, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? ---

23. SIGNATURE Reuben Hoffman, M.D.

Superintendent M. D. or other

Address Henryton, Maryland Date signed 6/9/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06374

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. Plte correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Md. Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 24 days
Stay in this community (yrs., or mos., or days): same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 617 North Bond Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: HORACE SEBORN HARRISON

3. (b) Social Security Number: 213-07-2455

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Annie Harrison
6(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): January 23, 1907

8. AGE:

Years	Months	Days	If less than one day
33	4	20	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Unknown

FATHER
12. Name: Horace Harrison
13. Birthplace: Maryland

MOTHER
14. Maiden name: Patty Allen
15. Birthplace: Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 15/1940 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: Cl a Co Md

18. Funeral director: Robert E. Wilkinson
Address: 1515 McElderry St

19. 6/11/40 (Date rec'd by registrar) 19____ Albert R. Counihan Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11, 1940 19____, at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18, 1939 19____, to June 11 19 40, and that I last saw h im alive on June 11 19 40.

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1939

Due to: --

Due to: --

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 6/11/40

RECEIVED
JUN 15 1940
BUREAU V. S.

06375

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 20 E. Green Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 66 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 20 E. Green
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Walter Scott Helm

3. (b) Social Security Number: None

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 4 - 1873

8. AGE: Years 66 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace: Westminster Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Electrician Retired

11. Industry or business: Gast Electric Co.

FATHER
12. Name: Beal Helm
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Radcliff
15. Birthplace: Maryland

16. Informant: Samuel J. Helm

Address: 20 E. Green St. Westminster, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof June 3. 1940 (month) (day) (year)

Cemetery or crematory: Meadow Branch

Location: Mr Westminster

18. Funeral director: H Bankard Son

Address: Westminster, Maryland

19. 6/1 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1940, at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9 1940, to June 1 1940, and that I last saw him alive on May 29 1940.

Immediate cause of death: Acute Pulmonary Edema

Due to: Hypertensive Cardio-Vascular Disease

Due to: Arteriosclerosis and chronic nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Milton A. Katz M.D.
M.D. or other

Address: Westminster Md Date signed 6-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JUL 5 1940
BUREAU V. S.

06376

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Nr. Westminster, - Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Carroll Co. Home

Stay in hospital or inst. (yrs., or mos., or days): 7 yrs.

Stay in this community (yrs., or mos., or days): 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rural.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: Sarah E. Barnes Herbig

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband ~~or wife~~: ? Herbig

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 11, 1852

8. AGE: Years: 88 Months: 3 Days: 8 If less than one day ____ hrs. ____ min.

9. Birthplace: Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: William H. Barnes
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Cordelia Becraft.
15. Birthplace: Maryland.

16. Informant: Lloyd Barnes
Address: R.D. Sykesville. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 21, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant

Location: Gamber, Carroll Co. Md

18. Funeral director: C. M. Waltz
Address: Winfield Md

19. 6/20 1940 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1940, at 1:30 PM

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from May 15 1940, to 6-19 1940, and that I last saw her alive on 6-18 1940.

Immediate cause of death: Prostration
Fractured hip

Due to

Due to

Other conditions: Old age
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION
5 weeks
Progressive
Protection

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidents Date of: 5-15-40

Where did injury occur? Nr. Westminster (City or town) Carroll (County) Md (State)

Injured at home, ~~farm, industry, public place (where?)~~

Means of injury: Fall Injured at work? No

23. SIGNATURE: N. C. Stone M. D. or other

Address: Westminster Date signed: 6-20-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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06377

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 4yrs. 6mOs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto. City
City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 513 S. Luzerne Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Theodore George Heyda

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): July 21,1908

8. AGE:

Years	Months	Days	If less than one day
33	10	11	... hrs. ... min.

9. Birthplace: unknown
(Town, county, and state)
10. Usual occupation: Steel Tester
11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Theophil-
15. Birthplace:

16. Informant: Records Springfield State Hosp
Address

17. X (Burial, cremation, or removal, Which?) Date thereof: 6-5-40 (month) (day) (year)
Cemetery or crematory: St. Stanislaus
Location: Dundalk ave
18. Funeral director: Joh J Duda
Address: 2829 Hudson St

19. June 1 1940 (Date rec'd by registrar) C. Harry Weiss Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1940, at 7:28p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 1939, to June 1 1940 and that I last saw him alive on June 1 1940

Immediate cause of death: Pulmonary Tuberculosis — Duration: Discovered 2/12/40
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Alan Jackson, M.D. M. D. or other
Address: Springfield State Hosp Date signed: 6/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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STATE OF MARYLAND—CERTIFICATE OF DEATH

06378

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (937)

County Carroll. Registration Dist. No. 75

Village or City Mr. Manchester No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 55 yrs. 11 mos. 17 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME AMELIA C. HORICH If U. S. Veteran, specify WAR

(a) Residence: No. Manchester Md. RD#1 St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female.	White	Widow

5e. If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvester Horich.

6. DATE OF BIRTH (month, day, and year) July 12 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	11	17.	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House Keeping

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Penna.

FATHER

13. NAME Geo. Garrett.

14. BIRTHPLACE (city or town) (State or country) Penna.

MOTHER

15. MAIDEN NAME Do not Know

16. BIRTHPLACE (city or town) (State or country) Penna.

17. INFORMANT Archie Zentz (Address) Manchester Md RD#1

18. BURIAL, CREMATION, OR REMOVAL

Place Riverview Cemetery Pa. Date July 2, 1940

19. UNDERTAKER W. G. Fream (Address) Hanover Pa.

20. FILED June 30, 1940 Mrs W. P. S. Fennes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June 29, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1940, to June 29, 1940

I last saw h alive on June 27, 1940; death is said to have occurred on the date stated above, at 9 a. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance, were as follows:

	Date of onset
Arteriosclerosis	2
Other Contributory Causes of Importance: Chronic Myocarditis	7

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W K S Fennes M. D.

(Address) Manchester Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or at **home**. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between retail **merchants** and wholesale **merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06379

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or insl. (yrs., or mos., or days): 5 months, 19 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1224 McCulloh Street
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: WILLIAM RANDOLPH JEFFERSON

3. (b) Social Security Number: 220-01-5480

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 22, 1907

8. AGE:

Years	Months	Days	If less than one day
33	1	27	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Shipping Clerk
11. Industry or business: Unknown

FATHER
12. Name: William Jefferson
13. Birthplace: Chula, Virginia

MOTHER
14. Maiden name: Mattie Wyatt
15. Birthplace: Tappahannock, Virginia

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 22 1940 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cemetery
Location:

18. Funeral director: Mrs Katie R Williams
Address: 322 n Schroeder st

19. 6/18/40 (Date rec'd by registrar) 19
Albert R Swankhaus Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18, 1940 19, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30, 19 39 to June 18 19 40, and that I last saw him alive on June 18, 19 40.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1939
Due to --	
Due to --	
Other conditions --	

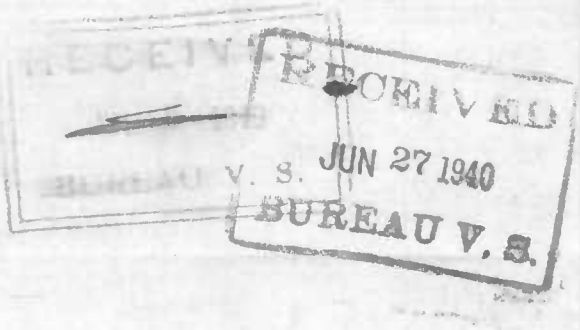
(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 6/18/40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JUN 27 1940
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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (83-a)

06380

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll, Co.
City or town Finksburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) about 18 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Finksburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. X
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR X

3. (a) FULL NAME Annie E. Jones
3. (b) Social Security Number X

4. Sex f.
5. Color or race White
6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband ~~or wife~~ Russell Jones
6(c) If alive, give age X years
7. Birth date of deceased (mo., day, yr.) Aug. 9th. 1847

8. AGE: Years 92 Months 10 Days 6 If less than one day ___ hrs. ___ min.

9. Birthplace Finksburg Carroll Co. Md.
(Town, county, and state)
10. Usual occupation X
11. Industry or business X

FATHER
12. Name Daniel Frazier
13. Birthplace Finksburg Md.

MOTHER
14. Maiden name Annie Shipley
15. Birthplace Carroll Co. Md.

16. Informant Agnes G. Frazier
Address Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 18 40 (month) (day) (year)
Cemetery ~~or crematory~~ Finksburg Methodist
Location Finksburg Maryland

19. Funeral director J. E. Myers Jr.
Address Westminster Md.

19. 6/17 19 40 Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 — 1940, at 3a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw her alive on June 15 1940

Immediate cause of death Acute cardiac Dilatation. Cerebral hemorrhage. Duration: six hours

Due to Rt. Hemiplegia. Cwg.

Due to arteriosclerosis chronic

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION
about 1 hr
9 hrs
unknown

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R Fouty MD
M.D. or other
Address Westminster Date signed 6/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JUL 5 1940
BUREAU V. S.

06381

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 1 month, 17 days

Stay in this community (yrs., or mos., or days) above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 104 Mechnic Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: THEODORE EDWARD JONES

3. (b) Social Security Number: 214-16-2378

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6(c) If alive, give age: none years

7. Birth date of deceased (mo., day, yr.): May 29, 1902

8. AGE: Years 38 | Months 0 | Days 5 | If less than one day ___ hrs. ___ min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Barber shop

FATHER
12. Name: Robert Fortune
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Beatrice Lee
15. Birthplace: Washington, D. C.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5, 1940 (month) (day) (year)

Cemetery or crematory: Cumberland Cemetery

Location: Cumberland Md.

18. Funeral director: C. Harry Weer

Address: Sykesville Md.

19. 6/3/40 19 (Date rec'd by registrar) Albert R Swankham Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1940 19 3:30P.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 1940 19 to June 3, 1940 19, and that I last saw him alive on June 3, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Feb 1939

Due to --

Due to --

Other conditions --
(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. Superintendent M. D. or other

Address Henryton, Maryland Date signed 6/3/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83-a CB 06382

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 129 E. Green St.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: Norfolk Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 418 Colonial Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Selina A. Kennedy

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife: Philip P. C. Kennedy
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8, 1868

8. AGE: Years	Months	Days	If less than one day
72	3	20	hrs. min.

9. Birthplace: Westminster, Carroll, Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: John C. Frizell
13. Birthplace: Maryland
MOTHER 14. Maiden name: Caroline Wright
15. Birthplace: Maryland
16. Informant: Mrs. Robert M. Hughes, Jr.
Address: Norfolk, Va.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 6/29/40 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 6/28 1940 (Date rec'd by registrar) F. Kennedy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28, 1940, at 4½ a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27th 1940, to June 28th 1940, and that I last saw her alive on June 27th 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: Hypertension	12 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. L. Billingsley M. D. or other
Address: Westminster, Md. Date signed: 6/28/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C6383

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 mos., 18 days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Marion Station Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: MATILDA ANN KENNEY

3. (b) Social Security Number: 213-18-4197

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: James Kenney

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1902

8. AGE: Years: 38 | Months: Unknown | Days: Unknown | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: unknown

FATHER 12. Name: William Milburn

13. Birthplace: Maryland

MOTHER 14. Maiden name: Sarah Carr

15. Birthplace: Maryland

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 11 40 (month) (day) (year)

Cemetery or crematory: marion Cemetery

Location: somerset County Md.

18. Funeral director: J W Filgham

Address: Marion md

19. 6/8/40 (Date rec'd by registrar) 19 Albert R. Swankhaus Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1940 19 , at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20, 1940 19 , to June 8, 1940 19 , and that I last saw her alive on June 8, 1940 19 .

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb. 1939
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

By autopsy: --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Superintendent Date signed 6/8/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06384

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Less than 1 day

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? Less than 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: ~~Carroll~~

City or town: ~~Sykesville~~ - Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. ~~Springfield State Hospital~~ (If rural, give LOCATION)

2.(a) If veteran, name war: 241 S. East Avenue

3. (a) FULL NAME: Henry Kerner

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Minnie Kerner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 31, 1860

8. AGE: Years: 79 Months: 7 Days: 22 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Michael Kerner

13. Birthplace: Maryland

MOTHER

14. Maiden name: Caroline Winkleman

15. Birthplace: Md.

16. Informant: Hospital Records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 25-1940 (month) (day) (year)

Cemetery or crematory: Immanuel

Location: Baltimore Md.

18. Funeral director: John C. Miller Inc.

Address: 1435 E. Oliver St

19. June 22 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1940, at 8:05 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Cerebral Hemorrhage

Due to: Arterio Sclerosis

Due to: .....

Other conditions: Senile Psychosis. (Include pregnancy within 3 months of death)

DURATION: 7

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Jas. T. Marsh, Deputy Medical Examiner M. D. or other

Address: New Windsor Md Date signed: 6/22/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 27 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

CERTIFICATE OF DEATH

06385

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Carroll Home of the Aged
Stay in hospital or insf. (yrs., or mos., or days) 9 years
Stay in this community (yrs., or mos., or days) 9 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. W. Main
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Jane King

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 4 - 1861

8. AGE:

Years	Months	Days	If less than one day
79	5	8	____ hrs. ____ min.

9. Birthplace Frederick County, Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name George King
13. Birthplace Fred. Co. Md.

MOTHER
14. Maiden name Margaret Mathany
15. Birthplace Fred. Co. Md.

16. Informant Mrs Millie Little matron
Address Carroll Home of the Aged Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 (month) 14 (day) 1940 (year)

Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Maryland

18. Funeral director H Bankard & Son
Address Westminster Maryland

19. 6/13 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1940, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1940, to June 12 1940; and that I last saw h[illegible] alive on June 11 1940.

Immediate cause of death Acute Hemiplegia — Duration: 3 days

Due to

Due to

Other conditions Chr. Nephritis — Duration: 10 years

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Bon M. D. or other
Address Westminster Md. Date signed 6/13/40

RECEIVED
JUL 5 1940
BUREAU V. S.

06386

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Rural Taneytown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Taneytown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. (Wolfis Mill)

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Herman Lawrence

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Infants

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 10 - 1940

8. AGE: Years | Months | Days 6 | If less than one day ____ hrs. ____ min.

9. Birthplace Taneytown, Carroll, Md (Town, county, and state)

10. Usual occupation Infants

11. Industry or business

FATHER 12. Name Herman Batchel

13. Birthplace Md

MOTHER 14. Maiden name Lucy Lawrence

15. Birthplace Maryland

16. Informant Lucy Lawrence

Address Taneytown Md. Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17 1940 (month) (day) (year)

Cemetery or crematory Banat

Location Tyrone, Md.

18. Funeral director C. Dusodson

Address Taneytown, Md.

19. June 17, 1940 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1940, at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h — alive on — 19 —

Immediate cause of death Inanition

Due to Premature birth

Due to

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Dt autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh. Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 6/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06387

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Near Manchester Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 77 - 1 -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: Near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary E. Leese

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: David H. Leese Deceased

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7th 1863

8. AGE:

Years	Months	Days	If less than one day
77	1	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER
12. Name: John Herbst
13. Birthplace: Maryland

MOTHER
14. Maiden name: Polly Sayble
15. Birthplace: Maryland

16. Informant: Harry Leese
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-10-40 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md

18. Funeral director: Jacob Wink's Sons
Address: Manchester Md

19. June 9 1940 Mrs. W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 1940, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1940, to June 7 1940, and that I last saw her alive on June 7 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Arteriosclerosis	
Due to: Hypertension	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William R S Denner M. D. or other
Address: Manchester Md Date signed 6/8/40

RECEIVED
JUL 5 1940
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

66388

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS Art (T)

1. PLACE OF DEATH:

County Carroll

City or town Hampstead, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) 12 days

Stay in this community (yrs., or mos., or days) 68 - 4 - 27

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Oden Elias Leister

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of ~~husband or~~ wife Alice May Leister

6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) January 30, 1872.

8. AGE:

Years	Months	Days	If less than one day
68	4	27.	____ hrs. ____ min.

9. Birthplace Hampstead, Maryland (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Agriculture

FATHER

12. Name Jacob D. Leister

13. Birthplace Maryland

MOTHER

14. Maiden name Zepp

15. Birthplace Maryland

16. Informant Alice May Leister

Address Hampstead, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28, 1940 (month) (day) (year)

Cemetery or crematory Leisters

Location Carroll Co. Md.

18. Funeral director Edw. C. Tipton

Address Hampstead Md.

19. June 26 1940 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1940, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1938, to June 26 1940, and that I last saw him alive on June 26 1940.

	DURATION
Immediate cause of death Coronary Occlusion	Suddenly.
Due to Degenerative Myocarditis	?
Due to	
Other conditions Arteriosclerotic Cardio-Vascular Lesions	?

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE Joseph E. Bush M.D. M. D. or other

Address Hampstead Md. Date signed 6-26-40

RECEIVED
JUL 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

06389

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Uniontown Rural mem
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 68

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Uniontown Rural Mem Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maggie Josephine Little

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or ~~wife~~ William A. Little
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1871

8. AGE:

Years	Months	Days	If less than one day
68	6	24	hrs. min.

9. Birthplace Uniontown Carroll Co Maryland (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Andrew Myers
13. Birthplace Maryland
MOTHER 14. Maiden name Manduba Myers
15. Birthplace Maryland
16. Informant Mrs Anna Fritz
Address Westminster, Md. R.D. #5
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2. 1940 (month) (day) (year)
Cemetery or crematory Meadow Branch Cemetery
Location Nr Westminster, Md.
18. Funeral director H Bankard Son
Address Westminster, Maryland
19. July 1 1940 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1940, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3, 1940, to June 30, 1940, and that I last saw her alive on June 29 1940.

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	
Due to Chronic Nephritis	1 yr
Due to Hypertension C.V. Renal Disease	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford M. Taylor M. D. or other
Address Westminster Date signed 7-1-40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

06390

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural, Hampstead, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Carroll.
City or town: Rural - Hampstead, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Virginia Lloyd.

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female.	White	Widowed.

6 (b) Name of husband or wife: Stephen Grafton Lloyd.
6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 23. 1850

8. AGE: Years	Months	Days	If less than one day
89	10	22.	____ hrs. ____ min.

9. Birthplace: Butler, Balto Co. Maryland
(Town, county, and state)
10. Usual occupation: None.
11. Industry or business:
FATHER 12. Name: Calep Pierce
13. Birthplace: Maryland.
MOTHER 14. Maiden name: ? Marsh.
15. Birthplace: Maryland.
16. Informant: Alverta May Keller.
Address: Hampstead, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17-40 (month) (day) (year)
Cemetery or crematory: Cedar Grove.
Location: Balto Co.
18. Funeral director: J. F. Ebert & Sons
Address: Reisterstown Md.
19. June 15 1940 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 1940, at 10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1939, to June 14 1940, and that I last saw her alive on June 11 1940

Immediate cause of death	DURATION
ARTERIO-Sclerotic Cardio-Renal ?	
Due to Vascular Disease	
Due to	
Other conditions Chronic Myocarditis	?

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph E. Buck M.D.
M. D. or other
Address: Hampstead, Md. Date signed 6-14-40

RECEIVED
JUL 3 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-8)

06391

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

County Carroll

City or town Rural Near Manchester
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. (Melrose)
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Leah Margaret Luckabaugh

3. (b) Social Security Number 213-~~18~~-9974

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or ~~wife~~ Charles F. Luckabaugh

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 8. 1890

8. AGE: Years 50 Months 4 Days 1 If less than one day ____ hrs. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER
12. Name Charles F. Deamer
13. Birthplace Germany

MOTHER
14. Maiden name Matilda Collins
15. Birthplace Penna.

16. Informant Charles F. Luckabaugh
Address Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-11-40 (month) (day) (year)

Cemetery or crematory cemetery

Location Sherman's Church Pa. York Co.

18. Funeral director Jacob Wink's Sons
Address Manchester Md

19. June 10 1940 Mrs. W. R. S. Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1940, at 5 a.m. 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death Cerebral Embolus

Due to Phlebitis - left leg

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION
7.
4 days.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 6/8/40

RECEIVED
JUL 5 1940
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

66392

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Home

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1244 Carroll Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES E. McCLOSKEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ellen McCloskey

6.(c) If alive, give age: Unk years

7. Birth date of deceased (mo., day, yr.): May 18, 1859

8. AGE: Years	Months	Days	If less than one day
81	0	28	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Policeman, retired

11. Industry or business: Baltimore police dept.

FATHER — 12. Name: James McCloskey

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Anna Dugan

15. Birthplace: Ireland

16. Informant: James McCloskey Jr.

Address: 1249 Carroll St. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-17-40 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location:

18. Funeral director: Leonard L. Pinder

Address: 5305 Harford Rd.

19. June 15 1940 (Date rec'd by registrar) A. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1940, at 5.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1940, to June 15 1940

and that I last saw him alive on June 14 1940

Immediate cause of death	DURATION
Chronic nephritis	Unk
Due to: arteriosclerosis	Unk
Due to:	
Other conditions: cerebral thrombosis	2 months?

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis Dandy jr. M.D. M.D. or other

Address: Springfield State Hospital Date signed: 6-15-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

06393

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME James Ray Mort

3. (b) Social Security Number

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 1, 1939

8. AGE: Years | Months 7 | Days 1 | If less than one day — hrs. — min.

9. Birthplace Taneytown, Carroll, Md (Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER 12. Name Ralph E. Mort

13. Birthplace Iowa

MOTHER 14. Maiden name Ethel R. Clingan

15. Birthplace Taneytown

16. Informant Ralph E. Mort

Address Taneytown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4, 1940. (month) (day) (year)

Cemetery or crematory Reformed

Location Taneytown, Md.

18. Funeral director Ed Frost Son

Address Taneytown, Md.

19. June 4, 1940 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1940, at 8 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 —, to — 19 —, and that I last saw h — alive on — 19 —.

Immediate cause of death Broncho-Pneumonia

Due to Inanition

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

DURATION

7

7 Mos

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. T. Marsh - Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 6/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 3 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

66394

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville Flohmille

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME — Parks

3. (b) Social Security Number

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1940

8. AGE: Years Months Days If less than one day 8 hrs. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Stanley Parks

13. Birthplace Md.

MOTHER 14. Maiden name Lillian M. Nickolas

15. Birthplace Md.

16. Informant Stanley Parks

Address Sykesville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18, 1940 (month) (day) (year)

Cemetery or crematory Providence

Location Gamber Md.

18. Funeral director C. H. Weer

Address Sykesville Md.

19. June 18 1940 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/17 1940, to 6/17 1940, and that I last saw her alive on 6/17 1940.

Immediate cause of death Premature birth

Due to 6 1/2 mos

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Barnes MD M. D. or other

Address Sykesville Md Date signed 6/18/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

06395

Reg. Dist. No. 81c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Carroll

City or town Union Bridge - Rural)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Union Bridge
(If outside city or town limits, write RURAL NEAR and give town)

Street No. McKinstrys Mills - Linwood Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles Albert Parrish.

3. (b) Social Security Number None.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

B (b) Name of husband or wife Martha Parrish.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 13. 1856

8. AGE:

Years	Months	Days	If less than one day
84	1	5	____ hrs. ____ min.

9. Birthplace Carroll Co. Md. (Union Bridge)
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business own Farm

FATHER
12. Name Richard Parrish

13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Sarah Sensency

15. Birthplace Carroll Co. Mayland

16. Informant Raymond A. Parrish.

Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20-40 (month) (day) (year)

Cemetery or crematory Mt View.

Location Union Bridge, Md.

18. Funeral director D. D. Hitch & Sons.

Address Union Bridge, Md.

19. June 19 1940 P. Eichman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18- 1940, at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10- 1940, to 6-18- 1940, and that I last saw him alive on 6/15 1940.

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M D
M. D. or other

Address Union Bridge Date signed 6/19/40

RECEIVED
JUL 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06396

Reg. Dist. No. 26

1. PLACE OF DEATH:
County Carroll
City or town Rural near Gamber
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 82 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Gamber Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joseph T. Parrish

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Mary A. Parrish
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 29, 1857

8. AGE:

Years	Months	Days	If less than one day
82	6	13	hrs. min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Stephen W. Parrish
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Wheeler
15. Birthplace Maryland

16. Informant William A. Parrish
Address Finksburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14, 1940 (month) (day) (year)
Cemetery or crematory Mount Pleasant Cemetery
Location Gamber, Md.
18. Funeral director J. Francis Reese
Address Westminster, Md.

19. 6/13 1940 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1940, at 5p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9th 1940, to June 11th 1940, and that I last saw h— alive on June 9th 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION 6/9

Due to arterio-sclerosis + senility — Senal years

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. T. Billingsley, M.D.
M. D. or other
Address Westminster, Md. Date signed 6/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06397

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 8 days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Girdletree Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: none
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: JAMES EDWARD PURNELL

3. (b) Social Security Number: 214-18-4917

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife: Catherine Purnell
Girdletree, Md. 6(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): December 16, 1917

8. AGE: Years	Months	Days	If less than one day
22	6	10	____ hrs. ____ min.

9. Birthplace: Girdletree, Worcester Co., Md (Town, county, and state)
10. Usual occupation: Garage Laborer
11. Industry or business: Unknown

FATHER
12. Name: Miller Purnell
13. Birthplace: Snow Hill, Maryland

MOTHER
14. Maiden name: Marguerite Armstrong
15. Birthplace: Philadelphia, Pennsylvania

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29, 1940 (month) (day) (year)
Cemetery or crematory: Liddle Lick Cemetery
Location: Liddle Lick Md.
18. Funeral director: Clay Dennis
Address: Snow Hill Md.

19. 6/26/40 (Date rec'd by registrar) Albert R. Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26, 1940 19____, at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1940 19____, to June 26, 1940, and that I last saw him alive on June 26, 1940 19____.

Immediate cause of death	--	Pulmonary Tuberculosis	DURATION: May 1939 (?)
Due to	--		
Due to	--		
Other conditions	--		

(Include pregnancy within 3 months of death)

Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Hneyrton, Maryland Date signed: 6/26/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (132)

06398

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 2 months, 7 days
Stay in this community (yrs., or mos., or days) Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1232 W. Lanvale St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME HERBERT ROLES

3. (b) Social Security Number 706-01-7324

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Irene Roles
1232 W. Lanvale St. 6(c) If alive, give age unknown years
7. Birth date of deceased (mo., day, yr.) May 3, 1892

8. AGE: Years 48 | Months 1 | Days 14 | If less than one day ___ hrs. ___ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business unknown

FATHER
12. Name Joseph Roles
13. Birthplace Maryland

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/20/40 (month) (day) (year)
Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18. Funeral director Joseph G. Locke, Jr.
Address 1304 N. Central Ave.

19. 6/17/40 (Date rec'd by registrar) 19 Albert R. Swankham Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1940 19 8:05 A.M., at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1940 19 , to June 17, 1940 19 , and that I last saw him alive on June 17, 1940 19 .

Immediate cause of death: Pulmonary Tuberculosis — Duration: Feb. 1940
Due to --
Due to --
Other conditions --
(Include pregnancy within 3 months of death)
Major findings:
Of operations --
Of autopsy --

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Superintendent
Address Henryton, Maryland Date signed 6/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 20 1940
BUREAU V. S.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

66399

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Same

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 40 E. 26th Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Bernard W. Spalding

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Etha S. Spalding

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 11. 1887

8. AGE: Years	Months	Days	If less than one day
52	10	8	..... hrs. ..... min.

9. Birthplace: Charles Co, Maryland (Town, county, and state)

10. Usual occupation: Grocer

11. Industry or business: Store

FATHER

12. Name: Basil W. Spalding

13. Birthplace: Maryland

MOTHER

14. Maiden name: Eliz. Green ~~Spalding~~

15. Birthplace: Maryland

16. Informant: Mrs. Etha S. Spalding

Address: 40 E. 26th St. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 21, 1940 (month) (day) (year)

Cemetery or crematory: Lorraine Cemetery

Location: Baltimore Md.

18. Funeral director: Charles H. Evans & Son Inc.

Address: 718 W. Mt. Royal Ave.

19. June 19 40 C. Harry Rees

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1940, at 2.45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1940, to June 19 1940 and that I last saw him alive on June 19 1940

	DURATION
Immediate cause of death: Pulmonary tuberculosis	July 1939
Due to: Probably carcinoma of stomach. Duration Unknown. Contrib.	
Due to:	
Other conditions: Epigastric mass, nature Unknown: Probably carcinoma. (Include pregnancy within 3 months of death)	July 1939

Major findings of operations: None

Date of op.:

Autopsy results: Autopsy was refused.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lewis Dansigner M. D. (M. D. or other)

Address: Springfield Hospital Date signed: 6-19-40

RECEIVED
JUN 21 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66400

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 4 yrs., 11 mos., 18days
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Mitchellville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Frank Spriggs

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Agnes Spriggs
6(c) If alive, give age: unknown years
7. Birth date of deceased (mo., day, yr.): July 4, 1872
8. AGE: Years: 67 Months: 11 Days: 19 If less than one day: hrs. min.
9. Birthplace: Collington, Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Unknown
FATHER 12. Name: Solomon Spriggs
13. Birthplace: Upper Marlboro, Maryland
MOTHER 14. Maiden name: Martha Jackson
15. Birthplace: Warrington, Md.
16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26/40 (month) (day) (year)
Cemetery or crematory: White marsh md
Location: Collington md
18. Funeral director: Clarence Forecare
Address: Mitchellville, md
19. 6/23/40 19 (Date rec'd by registrar) Albert R. Swanborn Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23, 1940 19 , at 8:40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1935 19 to June 23 19 40
and that I last saw h im alive on June 23, 1940 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 1934
Due to: --
Due to: --
Other conditions: --
(Include pregnancy within 3 months of death)
Major findings:
Of operations: --
Of autopsy: --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed 6/23/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

66401

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 year, 1 month
Stay in this community (yrs., or mos., or days): Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 625 Pitcher St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: CORRINE ELIZABETH STEWART

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

B (b) Name of husband or wife: John Stewart
6(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1904

8. AGE: Years	Months	Days	If less than one day
36	3	17	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Unknown

FATHER
12. Name: Henry Keys
13. Birthplace: Westminister, Md.

MOTHER
14. Maiden name: Annie Chambers
15. Birthplace: Westminister, Md.

18. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-7-1940 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Cemetery
Location: Anne Arundel Co Md
18. Funeral director: Mrs George H Holland
Address: 1631 Druid Hill Ave
19. 6/4/40 (Date rec'd by registrar) 19 Albert R Swackhamer Registrar
Deputy Local

MEDICAL CERTIFICATION 10:30 A.M

20. DATE OF DEATH: June 4, 1940 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4, 1939 19 to June 4, 1940 19 , and that I last saw her alive on June 4, 1940 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1938
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations --
Of autopsy --

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
Superintendent M. D. or other
Address: Henryton, Maryland Date signed: 6/4/40

RECEIVED
JUN 20 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

06402

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Finksburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 82 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Finksburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Jacob L. Stocksdale

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife: Ida F. Caple

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22, 1858

8. AGE:

Years	Months	Days	If less than one day
82	4	30	hrs. min.

9. Birthplace: Finksburg, Carroll, Md.
(Town, county, and state)

10. Usual occupation: House builder, ret'd.

11. Industry or business

FATHER
12. Name: William H. Stocksdale
13. Birthplace: Maryland

MOTHER
14. Maiden name: Georgianna Orndorff
15. Birthplace: Maryland

16. Informant: Howell K. Stocksdale
Address: Finksburg, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/23/40 (month) (day) (year)

Cemetery or crematory: Finksburg Cemetery

Location: Finksburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/23 1940 (Date rec'd by registrar) H. C. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 1940, at 7½ AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1940 to June 21 1940, and that I last saw h[illegible] alive on June 20 1940.

Immediate cause of death: Cerebral hemorrhage — DURATION: 4 days

Due to: hypertension

Due to: arteriosclerosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: James G. Saffell M. D. or other

Address: Reisterstown, Md. Date signed 6/22/40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-(a)

06403

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret B. Strevig

3. (b) Social Security Number 219-03-6260

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: William H. Strevig
6(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): April 7, 1875
8. AGE: Years: 65 Months: 2 Days: 2 If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name: Lewis Lippy
13. Birthplace: Maryland
MOTHER 14. Maiden name: Barbara M. Wentz
15. Birthplace: Penna.
16. Informant: William H Strevig
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-40 (month) (day) (year)
Cemetery or crematory: Cemeentry
Location: Manchester Md
18. Funeral director: Jacob Wink's Sons
Address: Manchester Md
19. June 11 1940 Mrs. W. R. L Denner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9th 1940, at 6 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28th 1939 to June 9th 1940, and that I last saw h sr alive on June 4th 1940

Immediate cause of death	DURATION
a Cerebral Hemmorrhage	5 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L M Resh M.D.
M. D. or other
Address: Hampstead Md Date signed 6/11/40

RECEIVED
JUL 5 1940
BUREAU V.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

06404

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs. 4 mo. 7 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 32 yrs. 4 mo. 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1301 Park Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Katherine Vesek

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 8 1840

8. AGE: Years 70 | Months 0 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Germany

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Philip J. Vesek

13. Birthplace Edenkoben, Germany

MOTHER 14. Maiden name Elizabeth Lahrist

15. Birthplace Clabrucken, Germany

16. Informant Hospital Records

Address Sykesville, Md.

17. (Burial, cremation, or removal. Which?) Date thereof 6-26-40 (month) (day) (year)

Cemetery or crematory Washington D.C.

Location

18. Funeral director Jos Gawler's Sons

Address 1756 Pa Ave Wash. D.C.

19. June 26 1940 (Date rec'd by registrar) Harry Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1940 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940 to June 26 1940 and that I last saw h[illegible] alive on June 26 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	6-25-40
Due to Cerebral Arteriosclerosis	1926
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mary M Rees M.D.

M. D. or other

Address Sykesville Date signed 6-26-40

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84E)

CERTIFICATE OF DEATH

06405

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr., 1 mo.

Stay in this community (yrs., or mos., or days): same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 202 West 21st Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Thomas Wilbon, Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August, 1920 (exact date unk.)

8. AGE:	Years	Months	Days	If less than one day
	19	10	Unk.	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: John T. Wilbon, Sr.

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Carroll

15. Birthplace: Maryland

16. Informant: Springfield Hospital Records
Address: Sykesville, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6-7-40 (month) (day) (year)

Cemetery or crematory: GREENMOUNT CEM

Location: BALTIMORE MD

18. Funeral director: WM J STICKNER + SONS

Address: NORTH + PA AVES BALTO. MD.

19. June 5 1940 (Date rec'd by registrar) C. Nanny Heer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5, 1940, at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 11, 1939, to June 5, 1940, and that I last saw him alive on June 5, 1940

	DURATION
Immediate cause of death: Acute Pulmonary Oedema	6/5/40
Due to: Cardiac exhaustion	6/5/40
Due to: Over activity	5/26/40
Other conditions: Schizophrenia prior to	4/5/39

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry F. Baer, M.D. M. D. or other

Address: Sykesville, Md. Date signed 6-5-40.

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06406

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 months, 1 day

Stay in this community (yrs., or mos., or days): same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 212 BlueBall Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: EMMA WILLIAMS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: James R. Williams

Same address 6(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Unknown (1873)

8. AGE: Years	Months	Days	If less than one day
67	?	?	____ hrs. ____ min.

9. Birthplace: Cecilton, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: unknown

FATHER

12. Name: Charles Carroll

13. Birthplace: Virginia

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17, 1940 (month) (day) (year)

Cemetery or crematory: Elkton Cemetery

Location: Elkton Md.

18. Funeral director: C. Harry Wells

Address: Sykesville Md.

19. 6/14/40 (Date rec'd by registrar) Albert R. Swankhaus — Registrar

Deputy Local

MEDICAL CERTIFICATION 11:40 A.M

20. DATE OF DEATH: June 14, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1940 to June 14, 1940, and that I last saw her alive on June 14, 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations --

Of autopsy --

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide -- Date of --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M. D.

Superintendent M. D. or other

Address: Henryton, Maryland Date signed: 6/14/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06407

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 17 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5320 39th St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Claude L. Woolley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Massachusetts
(Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business:

FATHER
12. Name: Lucien S.L. Woolley
13. Birthplace: Vermont

MOTHER
14. Maiden name: Eleanor Mosely
15. Birthplace: Massachusetts

16. Informant: Files Springfield State Hosp.
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1940 (month) (day) (year)
Cemetery or crematory: London Park
Location: Baltimore Md.

18. Funeral director: C.A. Steer
Address: Sykesville Md.

19. June 10, 19 40 (Date rec'd by registrar) C. Harry Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10, 1940 19 at 5:55 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 20 19 39 to June 10 19 40
and that I last saw h im alive on June 10 19 40

Immediate cause of death	DURATION
Cerebral Thrombosis	3mos
Due to: chronic myocarditis and generalized arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Alan Jackson, M.D.
M. D. or other
Address: Springfield State Hosp. Date signed 6/10/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 5 1940
BUREAU V. S.